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07/95 vii. Hospitals which have Medicaid general care admissions in the CHAP base period that are equal to or greater than one-half a standard deviation above the mean Medicaid general care admissions in their planning area shall receive a critical weighting factor of ten. If the hospital's Medicaid general care admissions are greater than the mean but less than one-half a standard deviation above the mean Medicaid general care admissions in their planning area the hospital shall receive a critical weighting factor of five.

07/95 viii. Hospitals which have a cost per day at 80 percent occupancy that is less than or equal to one-half a standard deviation below the mean cost per day at 80 percent occupancy in their planning area shall receive a critical weighting factor of ten. If the hospital's cost per day at 80 percent occupancy is greater than one-half a standard deviation below the mean cost per day at 80 percent occupancy but less than the mean cost per day at 80 percent occupancy in their planning area the hospital shall receive a critical weighting factor of five.

07/95 b. Is a major teaching hospital with 40 or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission of Dental Accreditation.

'98 c. Is a hospital with 3,200 ~~3,400~~ or more total Medicaid admissions in the CHAP base period.

==07/98 3. Be a hospital qualifying under C.2. above that has the highest number of Medicaid obstetrical care admissions in the CHAP base period. ~~which are equal to or greater than 2,400.~~

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==07/95 4. Be a hospital qualifying under C.2. above that on the last day of June preceding the CHAP rate period, is designated as a Level III or II Perinatal Center by the Illinois Department of Public Health, and that has a Medicaid inpatient utilization rate, as defined in Chapter VI, Section C.8.e. which is greater than one-half a standard deviation above the statewide mean Medicaid inpatient utilization rate, as defined in Chapter VI, Section C.8.c., and that has at least one obstetrical graduate medical education program accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.

==07/95 5. Be a children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children.

==07/95 D. Direct Hospital Adjustment (DHA) Adjustment. Calculation of the DHA is as follows:

==07/97 1. Hospitals qualifying under C.1. above shall receive an DHA of $60.00 multiplied by the DHA Medicaid days in the CHAP base period.

==07/97 2. Hospitals qualifying under C.2 or C.5. above shall receive an DHA of $30.00 multiplied by the DHA Medicaid inpatient days in the CHAP base period.

==07/97 3. Hospitals qualifying under C.5. above which have a Medicaid inpatient utilization rate, as defined in Chapter VI C.8.e., on the last day of June preceding the CHAP rate period, that is greater than eighty-five percent shall receive an additional $20.00 multiplied by the DHA Medicaid days in the CHAP base period.

==07/97 4. Hospitals qualifying under C.2.b. above shall receive an additional $10.00 multiplied by the DHA Medicaid days in the CHAP base period.

==07/98 5. Hospitals qualifying under subsection (C)(2)(a) and (C)(2)(b) of this Section will receive an additional $20 multiplied by DHA Medicaid days in the CHAP base period.

==07/98 ~~6~~5. Hospitals qualifying under C.3. or C.4. above shall receive an additional $120.00 multiplied by the DHA Medicaid days in the CHAP base period if their Medicaid inpatient utilization rate, as defined in Chapter VI C.8.e., on the last day of June preceding the CHAP rate period is equal to or greater than fifty percent; or $65.00 multiplied by the DHA Medicaid days in the CHAP base period if their Medicaid inpatient utilization rate, as defined in Chapter VI C.8.e., on the last day of June preceding the CHAP rate period is less than fifty percent.

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4. Hospitals qualifying under subsection C.1.c. above will receive the following rates:
   a. Hospitals will receive a rate of $30 per day.
   b. Hospitals located in Illinois and outside of HSA 6, that have a Medicaid inpatient utilization rate greater than 60 percent, will have their rate increased by $60 per day.
   c. Hospitals located in Illinois and inside HSA 6, that have a Medicaid inpatient utilization rate greater than 80 percent, will have their rate increased by $210 per day.
   d. Hospitals that are not located in Illinois that have a Medicaid inpatient utilization rate greater than 45 percent will have their rate increased by $35 per day.
   e. Hospitals with more than 3,200 Total admissions will have their rate increased by $125 per day.
5. Hospitals qualifying under subsection C.1.d. of this Section will receive the following rates:
   a. Hospitals will receive a rate of $45 per day.
   b. Hospitals with a MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $15 per day.
   c. Hospitals with a MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $50 per day.
6. Hospitals qualifying under subsection C.1.a.iii. above will will have their rates multplied by a factor of two.
7. Payments under this subsection C. will be made at least quarterly, beginning with the quarter ending December 31, 1999.
   a. Payment rates will be multiplied by the Total days.
   b. Total Payment Adjustments
      1. For the CHAP rate period occurring in State fiscal year 2000, total payments will equal the methodologies described above, less the amount the hospital received under DHA and SCHAP for the quarter beginning July 1, 1999. For hospitals not qualifying for CHAP, DHA and SCHAP payments for the quarter ending September 30, 1999, total payments will equal the methodologies described above.
      2. For CHAP rate periods occurring after State fiscal year 2000, total payments will equal the methodologies described above.
      3. Payments under this subsection C that are made to disproportionate share hospitals in accordance with Chapter VI.C.7. will be considered to be disproportionate share payments, except for payments made to hospitals as defined in Chapter XIII.

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SUPERSEDES
TN # _____

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==07/98 E. Rural Critical Hospital Adjustment Payments (RCHAP)

Rural Critical Hospital Adjustment Payments (RCHAP) shall be made to certain rural hospitals for certain inpatient admissions ~~occurring on or after September 1, 1996~~. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $400,000 per year. The Department shall also make a RCHAP adjustment payment to hospitals qualifying under this subsection at a rate that is the greater of:

1. the product of $745 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or

2. the product of $75 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.

07/96 F. Each eligible hospital's critical hospital adjustment payment for the CHAP rate period shall equal the sum of the amounts described in A., B., and D. above. The critical hospital adjustment payments shall be paid to eligible hospitals on a quarterly basis.

==06/97 G. For the month beginning June 1, 1997, and ending June 30, 1997, each hospital which qualifies under Part E.above shall receive an additional payment equal to an annual amount as described under Part E.above. For quarters beginning July 1, 1997, that rate, as described in Part E. above, shall be multiplied by a factor of two.

07/96 H. Critical Hospital Adjustment Limitations. Hospitals that qualify for trauma center adjustments under Section A. above shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in A.1. above, or a Level II trauma center as required for the adjustment described in A.2. or A.3. above. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased.

07/96 I. Critical Hospital Adjustment Payment Definitions. The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:

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10/99	~~12.~~ 10.	"RCHAP General Care Admission" means Medicaid General Care Admissions, as defined in subsection H.4. above, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.
10/99	~~13.~~ 11.	"RCHAP Obstetrical Care Admissions" means Medicaid General Care Admissions, as defined in subsection H.4. above, with a Diagnosis Related Group (DRG) of 370 through 375, occurring in the CHAP base period.
10/99	12.	"Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.
10/99	13.	"Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.
10/99	14.	"Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.
~~07/97~~	~~14.~~	~~Medicaid psychiatric days, as used in subsection H.18 below, means hospital inpatient days for the Supplemental CHAP base that are billed to the Department with a category of service 21.~~
~~07/97~~	~~15.~~	~~Medicaid rehabilitation days, as used in subsection H.18. below, means hospital inpatient days for the Supplemental CHAP base that are billed to the Department with a category of service 22.~~
~~07/97~~	~~16.~~	~~Total Medicaid admissions means hospital inpatient admissions for the Supplemental CHAP base period for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, and Medicare/Medicaid crossover admissions.~~
~~07/97~~	~~17.~~	~~Total Medicaid days means hospital inpatient days for the CHAP base period for recipients of medical assistance under Title XIX of the Social Security Act, excluding days for normal newborns, and Medicare/Medicaid crossover days.~~
~~07/97~~	~~18.~~	~~DHA Medicaid days means Total Medicaid days that include Medicaid psychiatric days and Medicaid rehabilitation days for the CHAP base period multiplied by a factor of two.~~

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~~07/98 I. Supplemental Critical Hospital Adjustment Payments (SCHAP)~~

~~Supplemental Critical Hospital Adjustment Payments (SCHAP) shall be made to all eligible hospitals, excluding county-owned hospitals and hospitals organized under the University of Illinois Hospital Act, as described in Section C.8 of Chapter II not meeting the criteria in subsection (1)(c) or (1)(h) below, for inpatient admissions occurring on or after July 1, 1998, in accordance with this Section.~~

~~07/97 1. To qualify for payments under this Section, a hospital must be located in Health Services Area (HSA) 6 or HSA 11 and satisfy one of the following criteria during the Supplemental CHAP base period:~~

~~07/97 a. A hospital's;~~

~~i. Medicaid obstetrical care admissions is greater than or equal to the mean number of Medicaid obstetrical care admissions for all hospitals located within the same Health Facilities Planning Area (HPA)., ii. Total critical weighting factor is greater than or equal to the mean Total critical weighting factors all hospitals located within the same HSA, and iii. Medicaid inpatient utilization rate(MIUR),is greater than or equal to the mean MIUR of all hospitals located within the same HSA.~~

~~b. A hospital has;~~

~~i. 3900 or more Medicaid admissions. ii. an occupancy percentage rate greater than the mean occupancy percentage rate, as defined by the Department of Public Health, of all hospitals within the same HSA, and~~

~~ii an MIUR greater than or equal to 55 percent.~~

~~c. A hospital that is a children's hospital, as defined in subsection C.3. of Chapter II, with a MIUR greater than or equal to 80 percent.~~

~~d. A hospital that is located in an HPA where all hospitals also are located in a Health professional shortage area (HPSA)., as designated in the Federal Register for the Supplemental CHAP base period, and has the greatest number of Medicaid obstetrical care admissions among all hospitals within that same HPA.~~

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~~e. A hospital that provides at least 900 Medicaid obstetrical admissions and possess an MIUR that is greater than or equal to 70 percent.~~

~~f. A hospital that has an MIUR that is greater than or equal to 75%.~~

~~07/98 g. A hospital with a level II perinatal center with an average length of stay that is less than 4.6 days and a cost to day ratio of $650 or less, as described in Chapter XV(C)(2)(a)(viii).~~

~~07/98 h. A children's hospital, as described in Chapter II(C)(3) with 4500 or more total Medicaid admissions during the Supplemental CHAP base period.~~

~~2. The Department will make payments during the CHAP rate period to qualifying SCHAP hospitals under the following methodology:~~

~~07/97 a. For hospitals qualifying under subsection 1.a. above that are located in HSA 6, the product of the Total Medicaid admissions multiplied by;~~

~~i. $620 for hospitals that,~~

~~A. have an MIUR that is greater than or equal to one standard deviation above the mean MIURs of all hospitals within HSA 6 and~~

~~B. have a Total critical weighting factor that is greater than or equal to one standard deviation above the mean of the Total critical weighting factors for all hospitals within HSA 6.~~

~~ii. $615 for hospitals that,~~

~~A. have an MIUR that is greater than or equal to one-half standard deviation, but less than one standard deviation, above the mean MIURs of all hospitals within HSA 6 and~~

~~B. have a Total critical weighting factor that is greater than or equal to one-half standard deviation, but less than one standard deviation, above the mean Total critical weighting factors of all hospitals within HSA 6.~~

~~iii. $610 for hospitals that,~~

~~A. have an MIUR that is greater than or equal to the mean, but less than one-half standard deviation, above the mean MIURs of all hospitals within HSA 6 and~~

~~B. have a Total critical weighting factor that is greater than or equal to the mean, but less than one-half standard deviation, above the mean Total critical weighting factors of all hospitals within HSA 6.~~

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~~b. For hospitals qualifying under subsection 1.a. above that are located in HSA 11, the product of the Total Medicaid admissions multiplied by;~~

~~i. $835 for hospitals that,~~

~~A. have an MIUR that is greater than or equal to one standard deviation above the mean MIURs of all hospitals within HSA 11 and~~

~~07/97~~

~~B. have a Total critical weighting factor that is greater than or equal to one standard deviation above the mean of the Total critical weighting factors for all hospitals within HSA 11.~~

~~ii. $775 for hospitals that,~~

~~A. have an MIUR that is greater than or equal to one-half standard deviation, but less than one standard deviation, above the mean MIURs of all hospitals within HSA 11 and~~

~~B. have a Total critical weighting factor that is greater than or equal to one-half standard deviation, but less than one standard deviation, above the mean Total critical weighting factors of all hospitals within HSA 11.~~

~~iii. $700 for hospitals that,~~

~~A. have an MIUR that is greater than or equal to the mean, but less than one-half standard deviation, above the mean MIURs of all hospitals within HSA 11 and~~

~~B. have a Total critical weighting factor that is greater than or equal to the mean, but less than one-half standard deviation, above the mean Total critical weighting factors of all hospitals within HSA 11.~~

~~c. For hospitals qualifying under subsection 1.b. above, the product of the Total Medicaid admissions, multiplied by $375.~~

~~d. For hospitals qualifying under subsection 1.c.. above, the product of the Total Medicaid days, multiplied by $125.~~

~~e. For hospitals qualifying under subsection 1.d. above, the product of the Total Medicaid days, multiplied by $99.50.~~

~~f. For hospitals qualifying under subsection 1.e. above and located in HSA 6, the product of the Total Medicaid admissions, multiplied by $875.~~

~~g. For hospitals qualifying under subsection 1.e. above and located in HSA 11, the product of the Total Medicaid admissions, multiplied by $835.~~

~~h. For hospitals qualifying under subsection 1.f. above and located in HSA 6 the product of the Total Medicaid admissions, multiplied by $420.~~

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~~i. For hospitals qualifying under subsection (1).(f). above and located in HSA 11, the product of the Total Medicaid admissions, multiplied by $400.~~

~~3. A hospital may only receive payments under one of the payment methodologies described in subsection 2. above. In the event that a hospital qualifies under more than one criteria under subsection a., the Department will reimburse the hospital using the payment methodology that allows the largest payment.~~

~~4. For any hospital that meets any of the qualifying criteria under subsection b. above, the Department will increase the SCHAP payment if, during the Supplemental CHAP base period, a hospital meets either or both of the conditions under 4.a. or 4.b. below.~~

~~a. A hospital has a;~~

~~i. Medicaid obstetrical care admissions greater than or equal to the mean number Medicaid obstetrical care admissions of all hospitals located in the qualifying hospital's HSA,~~

~~ii. Total critical weighting factor that is greater than or equal to the mean Total critical weighting factor of all hospitals located in the qualifying hospital's HPA, and~~

~~iii. an MIUR greater than or equal to the mean MIUR of all hospitals located in the qualifying hospital's HPA.~~

~~b. A hospital has an MIUR greater than or equal to 70%.~~

~~5. Additional SCHAP payments shall be paid under the following methodologies:~~

~~a. For hospitals qualifying under subsection 4.a. above and located in HSA 6, the product of $40 multiplied by the hospital's Total SCHAP admissions.~~

~~b. For hospitals qualifying under subsection 4.a. above and located in HSA 11, the product of $405 multiplied by the hospital's Total SCHAP admissions.~~

~~c. For hospitals qualifying under subsection 4.b. above and located in HSA 6, the product of $185 multiplied by the hospital's Total SCHAP admissions.~~

~~d. For hospitals qualifying under subsection 4.b. above and located in HSA 11, the product of $330 multiplied by the hospital's Total SCHAP admissions.~~

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~~e. For hospitals qualifying under subsection (1)(g) above, an additional payment shall be made that equals the product of $150 multiplied by the number of DHA days in the Supplemental CHAP base period.~~

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~~07/98~~ ~~f. For hospitals qualifying under subsection (1)(h) above, an additional payment shall be made that equals the product of $435 multiplied by the total Medicaid admissions in the Supplemental CHAP base period.~~

~~07/97~~ ~~6. SCHAP payments under this Section shall be paid on a quarterly basis.~~

~~7. Definitions;~~

~~a. "Supplemental CHAP base period" means services provided during State Fiscal Year 1995 and adjudicated by the Department by June 30, 1996.~~

~~b. "CHAP rate period", as used in this Section, means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year, and ending June 30 of the following year.~~

~~c. "Medicaid Inpatient Utilization Rate" (MIUR)., as used in this Section, means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12 month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 U.S.C.Sec.1396a et. seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in subsection c.3. of this Section. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.~~

~~d. "Medicaid obstetrical care admissions", as used in this Section, means hospital inpatient admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1,2,3, or 4; 660.0 through 669.9 with a 5th digit of 1,2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.~~

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